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Senator Orrin G. Hatch
104 Hart Senate Office Building
Washington D.C. 20510

Dear Senator Hatch:

I understand that you are to undertake an examination of the functioning of Administrative Law Judges (ALJs) in the Social Security disability hearings and review process. I have some issues I wish to bring to your attention; the views indicated in this letter and the attached document,[1] are my own as an individual and not as an employee of Social Security. I submit that the runaway expenditures and hearing workload in the disability program are the result of the Social Security Administration having ceded control of the program to the federal courts, through a decades-long accretion of court-made rules.

I have worked for Social Security for 38 years, since my second year of law school in 1972. I have served as a trial attorney (1974-1982) specializing in class action and appellate litigation, as an "Administrative Appeals Judge" (AALJ) on the Appeals Council (1982 -1987), and have been an Administrative Law Judge (ALJ) in the Seattle Hearing Office of the Office of Disability Adjudication and Review (ODAR) since November 1987. I have watched the erosion of Congressional intent for most of the past 38 years. In the agency bureaucracy there is no institutional memory, and consequently familiarity with Congressional intent has been lost.

From the outset of the disability program the courts have redefined it, step by step, from one where objective medical evidence and reasonable inferences based upon that objective medical evidence became secondary to subjective complaints of pain[2] and other symptoms, and subjective estimates of abilities by treating physicians. Over time the agency, rather than seek Supreme Court review of the appellate rulings, incorporated them into regulations and rulings.[3]

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[1] I have enclosed with this letter a paper regarding the courts' various glosses on the Social Security Act, which I wrote in 1993, addressed to the agency's "Disability Re-Engineering Project" (hereafter "Re-Engineering Paper").

[2] The Ninth Circuit legislated the "excess pain" standard, defined in 1986 in ***Cotton v. Bowen***, 799 F.2d 1404, 1407 (9th Cir. 1986) as follows: "(i)f the claimant submits objective medical findings that would normally produce a certain amount of pain, but testifies that she experiences pain at a higher level (hereinafter referred to as the claimant's "excess pain"), the Secretary is free to decide to disbelieve that testimony, ... but must make specific findings justifying that decision" (citations omitted).

[3] *Compare,* ***Polaski v. Heckler***, 739 F.2d 1320 (8th Cir. 1984), with Social Security Ruling (SSR) 88-13, *superseded*, SSR 96-5p, and see discussion, *infra*. The ***Polaski*** litigation precipitated an amendment to the Social Security Act, which was ignored by the courts. *See*, Note 14, *infra*, and Re-Engineering Paper pp 5-6.

The cumulative effect of this process is that the burden is now on the ALJ to disprove every subjective complaint and opinion. Consequently, rationalizing a denial decision is onerous, if not in many cases impossible, despite the underlying merits or lack thereof. This burden of *disproof*, together with constant hectoring for unrealistic production levels, is the reason allowance decisions have reached such an untenable magnitude.[4] Many ALJs are finding that favorable decisions are dictated by this court-designed system.[5] The allowance rate across the board, in my view, is indefensible in the context of the original legislative intent.[6]

To briefly summarize my position:

1: Around 1970, the Supplemental Security Income (SSI) disability program moved the responsibility for adult welfare benefits based on disability to the federal government from the former matching grant system. Social Security was charged with the responsibility for adjudicating disability for this new program, in partnership with the 50 states disability determination services. This dramatically changed the nature of the agency's clientele, from dealing with wage earners to dealing with welfare clientele, the majority with erratic work histories and marginal education. This is reflected in the number of cases which are either SSI only cases, or combined SSI – DIWC (disabled wage earner) (agency classification: SSDC) cases[7], as opposed to straight DIWC cases. I examined the next 37 cases I have set for hearing, the dockets for which happened to be on my desk prior to leaving work this afternoon. Only four

[4] The uncomfortable result of the subjective nature of disability adjudication, which allowance and denial rate comparisons among ALJs will easily reveal, is that whether a claimant is awarded disability benefits depends on which judge he draws in the lottery of random case assignments. This fact in itself can prey on the comfort of people with relatively low allowance rates, with such doubt perhaps leading some ALJs to conform to what is touted as "normative." In addition, the illogically high pay rates of some ALJs in some degree has caused the growth of the hearing workload through the proliferation of appeals of insubstantial cases; whether a case is insubstantial is irrelevant, and attorneys pursue such cases because they may draw an ALJ who will pay it despite the lack of merit.

[5] The Commissioner is urging ALJs to hear and decide 500 to 700 cases a year, a number that is unreasonable. Several years ago, the Associate Commissioner for Hearings and Appeals, under another administration, acknowledged that as a practical matter, hearing and deciding around 40 cases a month was the maximum practical given the nature of the inquiry and the frequently voluminous records involved (ALJs in the early 70's averaged 14 cases a month, and we filed affidavits in litigation in the mid- to late 70's touting the accomplishment of raising this to 27). It is a simple matter for attorneys to paper files with medical opinions, non-medical practitioner opinions, and descriptions of limitations from friends and neighbors of the claimants. Each and every one must be refuted, or the case will be remanded to examine those which are omitted.

[6] The original Congressional intent, although I have years ago lost my citation, was such that it was expected that 80% of those who would be found disabled would be found so as a result of having such dire medical conditions that they would meet one or more of specific listings of impairments based on objective medical criteria alone. Such cases, in theory, would not have to proceed to the administrative hearing level.

[7] The implication from the combined cases is that even with these wage earners, either there is a remote date last insured issue, or the claimant's earnings are so low that his Social Security benefits will be less than the approximately $700 paid to SSI recipients in the State of Washington.

are DIWC.[8] This is representative of the division of cases generally. SSI was the beginning of the agency's inability to cope with the adjudication workload.

2: The Office of the General Counsel (OGC) has never sought Supreme Court review of the "substantial evidence" decisions of the appellate courts, which impose undue burdens on ALJs to *disprove* disability, in the guise of rationale requirements. The rules of evidentiary burden promulgated by the courts, and subsequently adopted by the agency, include the treating physician rule, which I believe you will find to be instrumental in the vast majority of cases paid by ALJs. Rather than seek appeals to the Supreme Court, the agency has historically adopted these complicating rules into even more complicated regulations and rulings, attempting to mitigate their effect with pages of confusing explanatory verbiage.

A: For example, the agency regulation on medical opinion *in 1990*, 20 CFR 404.1527, read as follows:

> We are responsible for determining whether you are disabled. Therefore, a statement by your physician that you are *disabled* or *unable to work* does not mean that we will determine that you are disabled. We have to review the medical findings and other evidence that support a physician's statement that you are disabled.

The federal courts early on decided that a treating physician's opinion should be accorded significant weight. In the Ninth Circuit, such an opinion must be accorded *controlling* weight absent *clear and convincing reasons* why it should not. Thus, an ALJ, to deny a case, bears a significant burden of justification, which amounts to a burden of proof. The practical effect is to displace the authority to dispense public funds from the agency to physicians, who are interested in the global well-being of their patients,[9] rather than the well-being of the public fisc.

The agency did not appeal to the Supreme Court any of the cases imposing on the ALJ the burden of refuting treating physician opinions. Rather, they attempted to write around it, by redrafting 20 CFR 404.1527 so that the subsequent, 1991, version comprises approximately *360* column lines (three pages) in the Code of Federal Regulations (CFR), as opposed to the original three sentence, nine lines.[10]

B: The agency regulation on symptom evaluation (credibility) follows the same course. 20 CFR 404.1529, predicated on a series of un-appealed circuit court opinions, expanded from 16 column

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[8] I do not know how the agency currently allocates costs in the appeals process, but I was told in the late 70's and early 80's that the Office of the General Counsel charged all the costs for litigation in SSDC cases to the trust fund rather than general revenue, from which SSI payments are made.

[9] There have been several studies indicating that treating physicians, as a general proposition, will freely provide opinions for purposes of insurance coverage. *See e.g*., Physicians' Attitudes Toward Using Deception to Resolve Difficult Ethical Problems, Novack, *et al.,* Journal of the American Medical Association, May 26, l989.

[10] Subsequently, the Supreme Court in ***Black and Decker Disability Plan v. Nord,*** 538 U.S. 822 (2003), indicated, to my reading, that the only reason the treating physician rule existed in Social Security law was by dint of the 1991 regulation, c*odifying* the line of court cases on the subject.. They rejected plaintiff attempts, and the Ninth Circuit ruling, extending the treating physician rule beyond the Social Security program.

lines in the Code of Federal Regulations, to three pages.[11] There is a lengthy discussion of the Ninth Circuit's "excess pain" standard for review of credibility in the attached Re-Engineering Paper. The agency never attempted insofar as I know to appeal any of the various circuit rulings imposing a burden on the ALJ of disproving each and every allegation made by the claimant. I believe that you will also find claimant's subjective complaints to be instrumental in the awards of benefits by ALJs regardless of whether the allegations regarding symptoms and limitations are reasonable.[12] As the Re-Engineering Paper indicates, the "reasonable man" standard which is the predicate for most of our laws, following the British system, has no place in the disability review process, at least once the courts take jurisdiction.[13] Of note, the Supreme Court, to which the issue of court-mandated rules on crediting subjective complaints has not been taken by government appeal, nonetheless observed in ***Mathews v. Eldridge***, 424 U.S. 319, 344-45 (1976):

> By contrast, the decision whether to discontinue disability benefits will turn, in most cases, upon "routine, standard, and unbiased medical reports by physician specialists," ***Richardson v. Perales***, 402 U.S., at 404, concerning a subject whom they have personally examined. In ***Richardson*** the Court recognized the "reliability and probative worth of written medical reports," emphasizing that while there may be "professional disagreement with the medical conclusions" the "specter of questionable credibility and veracity is not present." *Id*., at 405, 407. To be sure, credibility and veracity may be a factor in the ultimate disability assessment in some cases. But procedural due process rules are shaped by the risk of error inherent in the truthfinding process as applied to the generality of cases, not the rare exceptions. The potential value of an evidentiary hearing, or even oral presentation to the decisionmaker, is substantially less in this context than in ***Goldberg***. (Footnote omitted).

The Court further notes, *Id.*, N. 28, that with respect to the issues presented in a disability termination case, "(t)he value of an evidentiary hearing, or even a limited oral presentation, to an accurate presentation of those factors to the decisionmaker does not appear substantial." *Also see,* ***Bowen v. Yuckert,*** 482 U.S. 137, 149 (1987) (noting that 42 USC 423(d)(2)(A) "was intended to

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[11] Met with scant success in dissuading the courts from their continued reversal of ALJ decisions, the agency in 1996, supplemented the six pages of regulations on the issues of treating opinions and subjective evidence by issuing approximately 40 pages of rulings (SSR's 96-1 through 96-9), also in effect ignored by the courts.

[12] The Seventh Circuit, in ***Moothart v. Bowen***, 934 F.2d 114, 117 (7th Cir. 1991) indicated that "absent the requirement of objective medical findings, disability hearings would turn into swearing contests." This is precisely what has transpired.

[13] The agency's failure to appeal these cases resulted in what one appellate judge (***Stewart v. Sullivan***, 881 F.2d 740, 746 (9th Cir. 1989) Sneed, Circuit Judge, *concurring*) called the problem of "adjectival and adverbial enhancement," *i.e.,* the language used by the courts to describe the ALJs burden to refute credibility increased with subsequent decisions. Judge Sneed charts the progression of the rationale requirement on the issue of credibility from a "specific finding," to a "specific and justifiable" finding, to a "convincing" justification, and predicts that "convincing" will soon be joined by "clearly." Judge Sneed apparently had missed that the "clear and convincing" standard had been pronounced four months earlier in ***Swenson v. Sullivan***, 876 F.2d 683, 687 (9th Cir. 1989). The Court in ***Fair v. Bowen***, 885 F.2d 597, 603-05 (9th Cir. 1989), referred to this process as "continually shifting the target at which we ask ALJs to aim." As it happens, by 1996 the requirement had transmuted to "*specific*, clear, and convinging." ***Smolen v. Chater*****,** 80 F.3d 1273, 1281 (9th Cir. 1996) (emphasis supplied, citation omitted).

reemphasize the *predominant* importance of medical factors in the disability determination."[14] S. Rep. No. 744, 90th Cong., 1st Sess., 48 (1967), U.S. Code Cong. & Admin. News 1967, p.2882." (*emphasis supplied*). *And see*, S. Rep. No. 744, at 2295 N. 7, and at 2295-96, N. 8.

The considerable liberalization of the disability program by the courts, moving the program away from an objective-based system of adjudication with the burden of proof on the claimant, to what is, at the hearing level, a subjective-based program with the burden to disprove the claimant's every allegation on the ALJ, could have been, I believe, predictably, forestalled by recourse to an evidently perceptive and receptive Supreme Court.[15]

D. Subsequent to the treating physician rule and the "excess pain" standard, the Ninth Circuit imposed on ALJs the duty to refute clearly and convincingly lay opinions from practitioners such as social workers, and lay testimony from relatives and friends of the claimant.[16] These burdens of refutation have been incorporated into rulings, such as SSR 06-03p: Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not "Acceptable Medical Sources" in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies. These considerations also factor into making denial decisions either too much work or impossible to rationalize successfully. Many ALJs, I am convinced, rationalize their allowance rate on this basis.[17]

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[14] 42 USC 423(d)(5)(A) (added by The Social Security Benefits Reform Act of l984) bolstered the emphasis on objective medical evidence by inserting into the Social Security Act the former regulatory requirement that:

> … there must be medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, which show the existence of a medical impairment that results from anatomical, physiological, or psychological abnormalities which could *reasonably be expected to produce the pain or other symptoms alleged* and which, when considered with all evidence required to be furnished under this paragraph (including statements of the individual or his physician as to the intensity and persistence of such pain or other symptoms which may reasonably be accepted as consistent with the medical signs and findings),…

(Emphasis supplied.) In a bizarre exercise, the Ninth Circuit subsequently read the legislative history of this amendment to mean the opposite of what the legislative history expressly stated, and found support in the amendment for the "excess pain" theory of adjudication pronounced by that circuit. *See,* ***Bunnell v. Sullivan***, 947 F.2d 341 (9th Cir. l991). See discussion in Re-Engineering Paper, attached, pp 5-6.

[15] At one point in about 1979 at the weekly staff meeting in OGC one younger attorney expressed his dismay at the failure of the agency to timely pursue an appeal by providing the Appellate Section of the Civil Division at the Department of Justice with an appeal recommendation (colloquially referred to as a "yes-appeal."); DJ had already request two extensions of time to file the appeal (Third Circuit, if memory serves). The response was "It's not your merit pay at issue." My belief has always been that at least in this department, and at least with respect to litigation, merit pay precipitated a culture of no risk, which inhibited the government from protecting the disability program. Merit pay no doubt currently plays a role in the constant initiatives to increase production numbers at the cost of quality and consistency of adjudication.

[16] ***Dodrill v. Shalala,*** 12 F.3d 915, 918 (9th Cir. 1993).

[17] The confluence of all these rules long ago tolled the death of the "substantial evidence test" of judicial review (42 U.S.C. 405g), which is lip-serviced regularly by the circuit courts, but ignored in practice. In ***Bunnell v. Sullivan***, *supra*, 947 F.2d at 348, Kozinski, Circuit Judge, *specially concurring only in the judgment*, referred to the pattern of judicial rulemaking for social security adjudication, as "an exercise of common-law decisionmaking spuriously imposed on a complex regulatory scheme" and a failure to allow "the political branches to resolve the intractable policy conflicts

3. In 1980 the agency promulgated the Medical-Vocational Guidelines (MVGs, which was a misguided attempt to promote uniformity. The Commissioner in the past couple of years indicated an intent to revisit and recast the MVGs and caved in, according to rumor, to lobbying by disabled advocacy groups and the claimant bar,[18] with no changes being made. Over the years, as the baby-boomers have aged, those who have been uneducated and unskilled and have contributed the least to the trust fund (and the general fund) have benefited the most. If you examine the MVGs, found at Appendix 2 to Subpart P of 20 CFR, you will find that at age 50 a person who can perform only sedentary work and has no skills is presumptively disabled. A person age 49 is not.[19] More importantly, many in the baby-boomer population, who wish to retire at age 62 (or even 60), and do not have skills, may be found disabled if he or she has a history of unskilled work, or a history of skilled work with skills which will not transfer to other work, even if he or she is capable of *light* work, *i.e.,* standing and walking six hours a day out of eight, and lifting and carrying 20 pounds occasionally, ten pounds frequently.

4. Only tangentially related to my general points, perhaps, is the agency's implementation of The Contract with America Advancement Act of 1996, Pub. L. 104-121, 110 Stat. 847 (relevant

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that inevitably arise in the implementation of social welfare legislation." Occasionally, judges vent their frustrations in dissents, such as that in ***Holohan v. Massanari***, 246 F.3d 1195, 1211 (9th Cir. 2001), Fernandez, Circuit Judge, *Concurring* and *Dissenting*:

> As is common with triers of fact, the majority opinion marshals every bit of evidence that would support its decision that Holohan should get benefits, and denigrates the opinions of the doctors who do not agree with that. For example, Dr. Hsieh's opinion is accepted, though she wrote very little and had never seen Holohan, while other physicians are dismissed with the comment that they are wrong, or conclusory, or checked the boxes. None of that is unusual. We regularly engage in complex locutions as we rummage through records and reweigh each piece of evidence, with no real deference whatsoever to those who work with and decide social security disability cases on a day-to-day basis. That approach enables us to cast a brume over the fact that we are actually retrying cases. However, it is one thing to find error; it is quite another to decide that the trier of fact, the expert agency, and the district court have perceptions of the record so inferior to ours that benefits must be ordered with no further ado.

[18] One difficulty with the administration of the disability program is that the agency spends much of its time when it proposes reforms, dealing with "stakeholders." Dealing with "stakeholders," *i.e.,* lobbyists for disabled and claimant representative organizations, results in such anomalies as the agency position that fibromyalgia is a medically determinable impairment, while recognizing that there is no objective clinical or laboratory evidence which establishes this disease (there are currently clinical trials advertised on local television for "childhood fibromyalgia" medications, indicating that we can soon expect "childhood fibromyalgia" applicants under the SSI disabled children program). By contrast, once objective criteria for chronic fatigue syndrome, a similar primarily subjectively based impairment, were promulgated by ruling (SSR 99-2p), claims for disability on the basis of this impairment, once significant in numbers, all but disappeared, at least in the Seattle area. Similar considerations appear to play into the 2002 obesity ruling (SSR 02-1p), which indicates that "the goals of treatment for obesity are generally modest, and treatment is often ineffective. Therefore, we will not find failure to follow prescribed treatment unless there is clear evidence that treatment would be successful." This ruling, again, follows similar verbiage in Ninth Circuit and other circuit decisions. Thus, there is another impossible burden of proof on an ALJ who might deny benefits because the claimant's disinclination to diet and exercise complicates his medical condition.

[19] The exception is a person who is age 45 to 49 who cannot speak English. This person, limited to sedentary work, is disabled. This results in payment of benefits to people in Puerto Rico despite the fact the official language is Spanish.

portions codified in scattered sections of 42 U.S. C.), which made substance addiction disorder a non-qualifying medical impairment. Many people are awarded benefits while addicted to alcohol and drugs because the ALJ is not able to parse out what limitations would be present if there was no addiction. The Ninth Circuit has ruled along with several others that the burden is upon the claimant to establish that substance addiction is not material to the state of being "disabled." ***Parra v. Astrue*****,** 481 F.3d 742 (9th 2007). The agency has taken the position that the burden is on the agency (*i.e*., ultimately, the ALJ) to establish that the claimant would not be disabled if there was no addiction. In ***Parra***, 481 F.3d 749-50, the court indicates that the agency approach is contrary to Congressional intent:

> such an interpretation is unpersuasive because it contradicts the purpose of the statute. As noted above, Congress sought through the CAAA "to discourage alcohol and drug abuse, or at least not to encourage it with a permanent government subsidy." Appellant's proposed rule provides the opposite incentive. An alcoholic claimant who presents inconclusive evidence of materiality has no incentive to stop drinking, because abstinence may resolve his disabling limitations and cause his claim to be rejected or his benefits terminated. His claim would be guaranteed only as long as his substance abuse continues--a scheme that effectively subsidizes substance abuse in contravention of the statute's purpose.

This is another category of cases in which an untenable burden of proof is placed on the ALJ and renders him/her more likely to simply pay a case, and in which, in my opinion, Congressional intent has been thwarted.

I am certain that if you interviewed ALJs around the country you would find other issues with the disability system which contribute to the current lack of uniformity, lack of accountability, and virtual impossibility to please "management." Interviewing bureaucrats will not uncover the problems inherent in the current structure. Interviewing "stakeholders" will not elicit ways to tighten up the process. The people in the "trenches" are the people who understand the practicalities of the process.

I have no dog in this hunt, so to speak. I maxed out my pension under CSRS last August, but have not yet been able to bring myself to retire; I am, likely unreasonably, invested in the disability program. I would like to see Congress turn its attention to some of the problems I have raised.

As noted, the views indicated in this letter and the attached document are my own as an individual and not as an employee of Social Security.

Sincerely,

Cc: Sen. Max Baucus

Verrell Dethloff

To: SSA - Disability Reengineering Project
P.O. Box 17052
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December 3, 1993

Fm: Verrell L. Dethloff, Jr.
Administrative Law Judge
Seattle, Washington Hearing Office (OHA)

Re: Reengineering Disability --- The Need to Reestablish the Original Definition of Disability

The burgeoning Social Security allowance rate at the administrative law judge level, and the concomitant growth of the payee roll itself, and the exploding workload for all adjudicators from the initial determination level through the federal courts, can all be traced to the departure of the program from its original precept. The disability program was originally defined as one which required that disability be objectively established. The statute, particularly as clarified after the 1967 Amendments, is clear on its face:

> For purposes of this subsection, a "physical or mental impairment" is an impairment that results from anatomical, physiological or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. (42 U.S.C. 423 (d)(3))

However, the federal courts early on declined to apply this strict test as it appears to have been intended. In Underwood v. Ribicoff, 298 F.2d 850, 854 (4th Cir. 1962), a germinative case in terms of disability substantial evidence review, the court declined to sustain the Secretary's decision, commenting that a finding of nondisability was possible on the record before it only if one adopted a highly technical and literal interpretation of the Act, which the Court declined to do.

This reluctance to strictly apply statutory provisions appears to follow, although the court does not cite, cases predating disability benefits which liberally construed old age and survivors benefits provisions of the Act. See, e.g., Schroeder v. Hobby, 222 F.2d 712, 715 (10th Cir. 1955) (mother's benefits); Wray v. Folson, 166 F. Supp. 390, 395 (W. D. Ark., 1958) (period of disability); Harper v. Flemming, 288 F.2d 61, 64 (4th Cir. 1961) (coverage issue). With scant exception the courts have followed this liberal construction in favor of the claimant (see, Schroeder, supra) without comment on the legislative history of the provision in question.

Disability insurance benefits were established by the Social Security Amendments of l956 (P.L. 90-248) (90th Cong., lst Sess.).

By 1967 Congress was already concerned with the manner in which the definition of disability was being interpreted in the courts.

This Congressional concern was precipitated by cases such as Ber v. Celebrezze, 332 F.2d 293 (2nd Cir. 1964), reversing the Secretary in a case of questionable objective medical basis on the rationale that claimant's pain was "very real to her" and that pain "real to the sufferer" can constitute a disability regardless of the source. Id., at 294-297.

This Congressional concern was manifested in the enactment of new section 223 (d) (3) of the Social Security Act, set out above. Prior to that time the courts had been guided only by old section 223 (c) (2), paralleling current 223 (d) (3), defining disability as the "inability to engage in any substantial gainful activity by reason of any medically determinable impairment..." The Senate Finance Committee notes that it "shares the concerns of the Committee on Ways and Means regarding the way this definition has been interpreted by the courts and the effects their interpretations have had and might have in the future on the administration of the disability program by the Social Security Administration." Discussing the courts' interpretation of this provision, the Finance Committee further notes:

> The studies of the Committee on Ways and Means indicate that over the past few years the rising cost of the disability insurance program is related, along with other factors, to the way in which the definition of disability has been interpreted. The committee therefore includes in its bill more precise guidelines that are to be used in determining the degree of disability which must exist in order to qualify for disability insurance benefits. S. Rep. No. 744, 90th Cong., 1st Sess., reprinted in (l967) U.S. Code. Cong. and Adm. News 2834, 2881.

The Finance Committee's concern with rising costs was voiced at a time when the number of disability recipients had risen from 455,371 in 1960 to 1,193,190 in 1966. The failure of Congressional efforts in 1967, and in 1984 (see discussion, below), is reflected in the fact that the disability recipient roll had risen by 1992 to 3,467,783. See, Social Security Bulletin, Annual Statistical Supplement 1993. The cost in dollars rose apace, from 40,668,000 in 1960, to 107,627,000 in 1966, to 2,171,080,000 in 1992. Id. These figures do not include auxilliary beneficiaries.

Among four primary concerns of the Senate Finance Committee in 1967 was "(t)he question of the kind of medical evidence necessary to establish the existence and severity of an impairment, and how conflicting medical opinions and evidence are to be resolved." In explaining what is meant by the enacted provision, section 223 (d) (3), quoted above, the Committee states:

> The impairment which is the basis for the disability must result from anatomical, physiological, or psychological abnormalities which can be shown to exist through the use of medically acceptable clinical and laboratory diagnostic techniques. Statements of the applicant or conclusions by others with respect to the nature or extent of impairment or disability do not establish the existence of disability unless they are supported by clinical or laboratory findings or other medically acceptable evidence confirming such statements or conclusions.... Id., at 2882-83.

To effectuate this legislative intent the Secretary promulgated 20 C.F.R. 404.1529 (1983) (compare, earlier, less explicit version, 20 C.F.R. 404.1526 (33 F.R. 11749, Aug. 20, 1968)) which provided:

> If you have a physical or mental impairment you may have symptoms (like pain, shortness of breath, weakness or nervousness). We consider all your symptoms, including pain and the extent to which signs and laboratory findings confirm these symptoms. The effects of all symptoms, including severe and prolonged pain, must be evaluated on the basis of a medically determinable impairment which can be shown to be the cause of the symptom. We will never find that you are disabled based on your symptoms, including pain, unless medical signs and findings show that there is a medical condition that could be reasonably expected to produce those symptoms.

There are three notable things about the l967 Amendments beyond the issues discussed above. First, Congress was already concerned with the rising costs of the disability program (see discussion, Ibid, at 2880). Second, Congress expected that the majority of cases would be decided on the basis of medical considerations alone: "(I)n most cases the decision that an individual is disabled can be made solely on the basis of an impairment ... of a level presumed (under administrative rules) ... to be sufficient so that ... it may be presumed that the person is unable to engage (in substantial gainful activity)." Third, the new statute, its legislative history, and the Secretary's regulatory interpretation of the statute were largely ignored, as the federal courts continued to liberalize the interpretation of disability through the mechanism of substantial evidence review.

Administrative Law Judges came under increasing criticism for attempting to give meaning to the Secretary's regulation in the context of particular cases, for, in essence attempting to effectuate congressional intent that the program be administered on an objective, and therefore, more uniform basis. An atmosphere of rancor arose on the part of reviewing courts which constantly derided administrative law judges for failing to properly apply rules established in court decisions.

These rules created an increasingly subjective system of adjudication of disability, and displaced the burden of proof on the ultimate issue of disability from the claimant to the administrative law judge. This was accomplished by interpreting substantial evidence to require that a claimant's allegations of disabling pain or other symptoms be established to be non-credible, rather than requiring that the claimant prove on a medical basis, as required by statute, that the allegations were credible. Similar rules were posited and proliferated with respect to pronouncements of disability on the part of treating physicians; if a treating physician pronounced a claimant disabled, it became incumbent on the administrative law judge to provide clear and convincing reasons not to accept this opinion.

An example of this subjectivization of the disability adjudication process may be seen in the Ninth Circuit Court of Appeals. By l986 the Ninth Circuit refined its position to the "excess pain" standard. In Cotton v. Bowen, 799 F.2d 1404, 1407 (9th Cir. 1986), the court stated "(i)f the claimant submits objective medical findings that would normally produce a certain amount of pain, but testifies that she experiences pain at a higher level (hereinafter referred to as the claimant's "excess pain"), the Secretary is free to decide to disbelieve that testimony, ... but must make specific findings justifying that decision" (citations omitted).

That this requirement of "findings justifying that decision" amounts to a burden of proof has been recognized by the courts. The Ninth Circuit in a subsequent case, Fair v. Bowen, 885 F.2d 597, 603-605 (9th Cir. 1989), discusses how the administrative law judge may "rebut" claims of "excess pain," and further notes the development in the circuit of an "intricate assortment of judicially-created rules" wherein the administrative law judge must "convincingly justify" his rejection of testimony, while the circuit rules on a piece-meal basis that the reasons offered in given decisions are insufficient.

Circuit Judge Sneed, concurring in Stewart v. Sullivan, 881 F.2d 740, 746 (9th Cir. 1989), notes his "belief that it is extremely difficult for the Secretary to refute successfully an excess pain claim." Judge Sneed further notes the unreasonable possibility of the Secretary enrolling the investigatory aid of the FBI to "ascertain the genuineness of these claims" and similarly dismisses the creation of the Secretary's own investigatory arm.

Judge Sneed appears to endorse the result reached in Stewart, a remand to pay the case rather than for further action, only because he questions the proper disposition in a case where the Secretary has "failed to carry his burden, whatever it may be, with respect to "excess pain" claims."

Both Judge Sneed, in Stewart, and the court in Fair, note the changing nature of the mark an administrative law judge must hit in rationalizing his cases. The crux of the difficulty with the subjective approach taken toward disability case adjudication by the courts, and the effect of this approach on both the disability roll (in terms of allowance rate) and the administrative process, is presaged by footnote 3 in the Fair decision, 885 F2.d, at 602:

> The growth in the number of excess pain cases may be a self-perpetuating phenomenom. As we decide more cases involving pain, the law regarding pain acquires more and finer refinements. The time lag between an ALJ's decision in a particular case and the day that case comes before us is often two years or longer; ALJs are thus often making excess pain determinations according to law that has been superseded by the time the cases are judicially reviewed. By continually shifting the target at which we ask ALJs to aim, we no doubt make it harder for them to hit it. The likelihood that an excess pain claimant will win reversal on appeal because the ALJ applied the wrong law accordingly increases, causing a corresponding increase in the number of excess pain cases appealed. And so on.

What is all the more troubling about the development of this line of cases and a similar line requiring the rebuttal of treating physicians' opinions of disability (see, e.g., Day v. Weinberger, 522 F2.d 1154, 1156 (9th Cir., 1975)), is that this line of cases persisted and gathered steam not only after the l967 Amendments, but after the l984 Amendments as well.

In l984, Congress revisited the issue of the objective definition of disability and the activism of the courts in interpreting the statute. In a bizarre exercise, the Ninth Circuit subsequently read the legislative history of the l984 Amendments (The Social Security Benefits Reform Act of l984) to mean the opposite of what the legislative history expressly stated was the intent of the amendments, and exactly opposite of what the express language of the new statute stated:

> An individual shall not be considered to be under a disability unless he furnishes such medical and other evidence of the existence thereof as the Secretary may require. An individual's statement as to pain ... shall not alone be conclusive evidence of disability as defined in this section; there must be medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, which show the existence of a medical impairment that results from anatomical, physiological, or psychological abnormalities which could reasonably be expected to produce the pain ... alleged and which, when considered with all evidence required to be furnished under this paragraph (including statements of the individual or his physician as to the intensity and persistence of such pain ... which may reasonably be accepted as consistent with the medical signs and findings), would lead to a conclusion that the individual is under a disability. Objective medical evidence of pain ... established by medically acceptable clinical or laboratory techniques ... must be considered in reaching a conclusion as to whether the individual is under a disability. (42 U.S.C. 423(d)(5)(A) (emphasis supplied)

The Senate Finance Committee report emphasized the explicit intent of section 423(d)(5)(A) as:

> a codification of the regulations and policies currently followed by the Administration. This rule prohibits basing eligibility for benefits solely on subjective allegations of pain (or other symptoms). There must be evidence of an underlying medical condition and (1) there must be objective medical evidence to confirm the severity of the alleged pain arising from that condition or (2) the objectively determined medical condition must be of a severity which can reasonably be expected to give rise to the alleged pain. S.Rep. No. 466 at 24, 98th Cong., 2d Sess. (l984) (emphasis supplied).

Again, this legislative action was precipitated by Congress' perception of misguided judicial activity: "if courts ignore the Secretary's regulatory authority and the expressed Congressional concerns for careful administration, national uniformity and verifiable evidence, the Committee has little choice but to draw the statute as narrowly as possible." Id., at 23-24. Indeed, Senator Long, Chairman of the Senate Finance Committee, specifically noted with reference to the district court

opinion in Polaski v. Heckler, 585 F.Supp. 1004, 1008-09 (D.Minn., l983), aff'd,739 F.2d 1320 (8th Cir., l984, ordered remanded on other grounds, 751 F.2d 943 (8th Cir., 1984), vacated 476 U.S. 1167 (1986), which had held that medical evidence need not fully support a claimant's complaints of pain:

> On the basis of (the district judge's) finding that the Secretary was not obeying what he calls "Eighth Circuit law," this judge ordered the Secretary to substitute his policy judgment for hers (sic) (and that of Congress) in carrying out the Social Security Act in an area covering seven States.
>
> This case would not be so troubling if it were atypical. But apparently, it is almost the judicial norm. Courts do, of course, have the responsibility to carry out the law and resolve questions of interpretation. In so doing, however, they should be guided by the statute and its legislative history.... If the judge in this case had bothered to examine the statute and legislative history, he would have ample evidence of Congress' concern not that the law be more broadly construed, but that it be more narrowly construed. He would also have found great concern on the part of Congress that the law be administered more uniformly.... Circuit courts are not regional legislatures.

130 Cong. Rec. S6211 (daily ed. May 22, 1984). Senator Long further noted that the result of this judicial interpretation would be that "ultimately, ... eligibility would depend upon the subjective credibility judgment made by each individual adjudicator of claims." See, 130 Cong. Rec. S11458 (daily ed. Sept. 19, 1984.)

Considerable legislative comment to similar effect may be found discussed in Bates v. Sullivan, 894 F.2d 1059, 1067-68 (9th Cir., 1990) (Eugene A. Wright, and Wallace, Circuit Judges, concurring).

In the face of this considerable legislative criticism of the courts' historic approach to evidentiary matters under the Social Security Act disability provisions, and flying in the face of the new statute, the Courts maintained the position repudiated by Congress. One emphatic example of this is the Ninth Circuit's en banc revisiting of the issue of subjective evidence in Bunnell v. Sullivan, 947 F.2d 341 (9th Cir., l991). In a majority opinion that defies logic and ignores completely the applicable regulations and the legislative record pertaining to the issue of pain (see, Kozinski, Circuit Judge, specially concurring only in the judgment) the Ninth Circuit finds support in the 1984 Amendment, 42 U.S.C. 423(d)(5)(A), for the "excess pain" standard it had judicially legislated in Cotton v. Bowen, 799 F.2d 1404, supra. The Bunnell opinion and its advocacy of the position scathingly rejected by Congress is, as noted by Judge Kozinski in his concurrence 947 F.2d, at 348, "an exercise of common-law decisionmaking spuriously imposed on a complex regulatory scheme" and a failure to allow "the political branches to resolve the intractable policy conflicts that inevitably arise in the implementation of social welfare legislation."

What is all the more troubling in the face of cases such as Bunnell, which have, as warned by Senator Long, supra, created a system wherein eligibility depends upon "the subjective credibility judgment made by each individual adjudicator," is that the political branches referred to by Judge Kozinski in Bunnell have failed in their responsibility to insure the integrity of the program. Notably, in Bunnell itself, the agency through its representative at oral argument essentially conceded the validity of Cotton's "excess pain" pronouncement. See, Bunnell concurrence, 947 F.2d, at 353. Congress has failed to address this pressing issue since the l984 Amendments, and allowed the applicable "sunset" provision to take effect, rendering the provisions of 42 U.S.C. 423(d)(5)(A) inapplicable to adjudications made after January 1, 1987. Pub.L. No. 98-460, section 3(a)(3), 98 Stat. l799-1800 (1984).

Further involvement by Congress in this area is clearly required, although perhaps not politically palatable. The constituency favorably disposed to taking the judicially created subjectivity out of the disability program is not so easily identifiable as the social security claimant bar, and indeed the social security claimant and recipient roll.

Congress has failed to further act or inquire into the issue of subjectivity in any organized or meaningful fashion, despite recommendations that it act to extend the 1984 amendment by the Commission on the Evaluation of Pain, which was itself established by section 3 of Pub. L. 98-460.

Moreover, the Pain Commission's report reflects the magnitude of the problem of subjective evidence: while filling three or four pages of its report with 13 recommendations, including extension of 42 U.S.C. 423(d)(5)(A) past its expiration rate pending further study of the issue, the Commission offers nothing to the adjudicator in terms of how to "judge" pain. The judgment of pain is left by the Commission, by the Social Security Administration, and by Congress, to the subjective judgment of the adjudicator; the adjudication of pain is left as the courts have established it, essentially a rebuttable presumption created by allegations, to be rebutted with no source for investigation, against a backdrop of ever changing judicially created rules.

In such a context, there is little reason to wonder at the multiplying number of claims and allowances, and the expanded roll of disability recipients currently exhausting the Disability Trust Fund, now estimated by some sources to dry up within five years. Litigation at all levels continues to grow as the subjectivity of the system and the changeability of the applicable rules encourages the pursuit of appeals.

Little effective guidance is provided either by Social Security Ruling 88-13 (codifying Polaski, supra) the basis for the government's essential acquiesence in the Bunnell case, or in more recently added regulations. Regulations on the issue of subjective evidence and treating physicians' opinions were drafted and went into effect in August and in November 1991. See, e.g., 20 CFR 404.1527, 1529 (56 FR 36960, Aug. 1, 1991; 56 FR 57941, Nov. 14, 1991).

The new regulation on subjective symptoms, which once was one brief paragraph, now covers six

and a half columns of the Code of Federal Regulations with text which confuses more that it elucidates, and which has carried no discernible weight with reviewing courts. The administrative law judge remains fundamentally alone in assessing subjective evidence, without resources or black letter underlying philosophy to carry evidentiary burdens displaced to him by the courts.

In the face of this judicial redefinition of fundamental aspects of the social security disability program, the Social Security Administration, guided by the Department of Health and Human Services Office of the General Counsel embarked upon a questionable tactic of "non-acquiescence," with, apparently, either the active endorsement of the Appellate Division of the Justice Department, or with that Division's tacit approval.

In any event, rather than appeal much of the troublesome precedent which flowed from the courts, the agency proceeded to simply ignore such precedent in deciding similar issues in subsequent cases. This in turn was the cause of a considerable rift between political bureaucrats on one side and the Administrative Law Judges, who by vocational prerequisite for their positions came from a tradition of recognizing and honoring the controlling nature of judicial appellate decisions. The faceoff between the agency and the courts became rather bitter, and the ALJ's were caught in the middle.

The Office of Hearings and Appeals Handbook, published in l976 stated: "(W)here a district or circuit court(')s decision contains interpretations of law, regulations, or rulings (that) are inconsistent with the Secretary's interpretations, the (administrative law judges) should not consider such decisions binding on future cases simply because the case is not appealed." Id., section 1-161, quoted in Steiberger v. Heckler, 615 F. Supp. 1315, 1351 (S.D.N.Y., 1985), vacated on other grounds, 801 F.2d 29 (2 Cir., 1986).

Prior to the appearance of this handbook provision, termed by one commentator to be SSA's "comprehensive nonacquiescence policy" (see, SSA Nonacquiescence, Kubitschek, University of Pittsburg Law Review, Vol. 50, No. 2 (Winter 1989)), SSA had issued individual "notices of non-acquiescence," directing that specific court decisions be disregarded. See, e.g., Social Security Ruling 66-23c, SSR 67-14c, and SSR 68-48c. Only these three nonacquiescence rulings were issued prior to 1976. Following the pronouncement of the l976 OHA Handbook the agency nonetheless continued to issue individual rulings. See, e.g., SSR's 80-10c, 80-11c, 81-28c, 81-1c, 82-10c, 82-33c, 82-49c.

In l985 SSA revised its approach and indicated it would henceforth issue Notices of Acquiescence. Interim Circular 185, June 3, l985, reprinted in Steiberger v. Heckler, supra, at 1403. Under this procedure the agency now issues Acquiescence Rulings "identifying circuit court decisions which are at variance with established SSA policy" and "explaining how SSA will apply the decision within the circuit." Acquiescence rulings began in l986 with 23 issuances and continue apace. For example, in 1992, SSA issued ten acquiescence rulings, three of which revised earlier acquiescence rulings (i.e., SSR's 86-2R(2), 86-18R(5), 86-19R(11)).

If an acquiescence ruling is in effect, the agency will follow the law of the circuit unless the Appeals Council identifies the case as one which on its facts will provide a good precedent to relitigate the holding at issue. See, again, Interim Circular 185. Administrative Law Judges are now dealing in a milieu wherein the agency has engaged in a process termed by Professor Carolyn A. Kubitschek (see, SSA Nonacquiescence, supra) "silent nonacquiescence."

An example of this is the agency's new subjective evidence regulation, 20 C.F.R. 404.1529, the six and one half column exercise previously referred to, which is largely an effort in attempting to circumvent the "excess pain" theory of Cotton v. Bowen, supra, and similar cases dating all the way back to Ber v. Celebrezze, supra, despite the apparent representation to the court in Bunnell of having effectively endorsed Cotton.

Paradoxically, prior to the issuance of the new regulations the Appeals Council persisted in remanding cases within the Ninth Circuit's jurisdiction for failure to conform to the "excess pain" holding of Cotton and requiring adherence in the same remand orders to SSR-88-13, which contrary to the "excess pain" approach, requires that there be an impairment which could "reasonably be expected" to cause the pain alleged.

The result of the failure to adhere to circuit court precedent has been an explosive growth in the number of disability cases filed in the federal courts. In fiscal l984 18,968 disability cases were decided by federal courts; in l985 26,487 decisions were issued. Of these decisions, the Secretary was affirmed only 2,676 times in l984, and only 3,981 times in 1985. See SOC. SEC. ADMIN., Operational Report of the Office of Hearings and Appeals, l984, l985. These are the most recent figures I have available.

Congress has failed to address in meaningful fashion either the redefinition of disability through case law or the confrontation and resultant proliferation of such case law which has followed the nonacquiescence policy of SSA. Congress has recognized the confrontation between the agency and the courts noting "(t)he increasing number and intensity of confrontations between the agency and the courts as the SSA refuses to apply circuit court (precedent)." H.R. Rep. No. 618, 98th Cong., 2d Sess 25, reprinted in l984 U. S. Code Cong. and Adm News 3038. However, Congress has failed to take steps to limit either this activity by the agency or the expansive and subjective approach toward disability taken by the federal courts since the l984 Amendments.

Several notable issues were addressed by those amendments: 42 U.S.C. 423 (d)(5)(A), addressing the issue of pain was enacted and subsequently ignored by the courts, as explained supra; and Congress enacted the medical improvement standard for cessation of disability actions at 42 U.S.C. 423(f) (sec. 2(a), Social Security Disability Benefits Reform Act of 1984). The former is an effort to guide the courts, which the courts laboriously misconstrued (see, Bunnell v. Sullivan, Circuit Judge Kozinski concurring specially, supra), and the latter is a legislative endorsement of the "medical improvement" standard of Lopez v. Heckler, 572 F. Supp. 26 (C.D. Cal.), aff'd in part and

rev'd in part, 725 F.2d 1489 (9 Cir., 1983), vacated on other grounds, 469 U.S. 1082 (1984), and similar cases.

Congress similarly enacted additional guidelines on the evaluation of mental impairments following legal challenges to the agency's standards and procedures. See, 42 U.S.C. 421 note; sect. 5, Social Security Disability Benefits Reform Act of 1984. A comparison of these developments results in the conclusion that while Congress can pass statutes to conform the agency to judicial precedent, Congress cannot pass statutes to cause the federal judiciary to follow Congressional intent, or give more than lip service to the concept of deference to agency interpretation of statutes.

Despite the aforementioned efforts to legislate acquiescence in two specific areas, the Social Security Disability Benefits Reform Act of 1984 failed to contain provisions reflecting either House or Senate proposals which would specifically address the issues of nonacquiescence, the Conference Committee failing to resolve major differences between the two offerings. See, H.R. 3755, 98th Cong., 1st Sess., 130 Cong. Rec. H1987, 1990 (daily ed., Mar. 27, 1984); S. 476, 98th Cong., 1st Sess., section 7(a)(1) (1984); and H.R. Conf. Rep. No. 98-1039, 98th Cong., 2d Sess. 37, reprinted in 1984 U.S. Code Cong and Adm. News 3080: "(b)y refusing to apply circuit court interpretations and by not promptly seeking review by the Supreme Court, the Secretary forces beneficiaries to re-litigate the same issue over and over again in the circuit, at substantial expense to both beneficiaries and the federal government. This is clearly an undesirable consequence." Compare, Administrative Conference Proposal, 53 Fed. Reg. 12,444 (1988), which would preserve nonacquiescence with wide dissemination to the public and relevant government officials and a statement of reasons for nonacquiescence.

Thus Congress and the political branches of the government have left unsettled resolution of the subjective nature of the disability program and the conflict this has created, exacerbated as are many other issues by the nonacquiescence policy currently employed by SSA. The administrative law judges remain in the position of fashioning hearing decisions which more and more frequently take on the aspect of a brief in support of a decision rather than the proper aspect of a judicial document.

The subjectivity of the process increases the workload in a continuing spiral and appears to many judges to result in undeserving and incorrect awards of benefits as the requirements to prove disability are displaced to judges who have no resources to disprove the allegations of claimants or the freely-given opinions of disability offered by treating physicians. See in this latter regard, Physicians' Attitudes Toward Using Deception to Resolve Difficult Ethical Problems, Novack, et al., Journal of the American Medical Association, May 26, l989 (indicating statistically a willingness of physicians to lie to insurers for the global well-being of their patients).